Application for Essential Community Provider Trust Fund Award
Instructions for Completion
11-24-2008

The application for awards from the essential community provider trust fund can be found on the Executive Office of Health and Human Services (EOHHS) website at www.mass.gov/eohhs or the Division of Health Care Finance and Policy's (DHCFP) website at www.mass.gov/dhcfp. It should be completed by any hospital or community health center that believes it meets the criteria outlined in the cover letter (available online), that was mailed to each facility on November 24, 2008. Providers do not have to file an application to participate in provider rate distributions, if any, from the Fund. However, providers must submit an application to be considered for grant distributions from the Fund.

This application is an Excel worksheet that should be downloaded and completed by each applicant. The application should be completed in its entirety and e-mailed, as an attachment, to an e-mail to kevin.flynn@state.ma.us **no later than 4:00 p.m. on Friday, December 12, 2008. Please DO NOT change the form, since the data will be copied and pasted to a separate workbook for comparative analysis.**

Applicants SHOULD INPUT DATA ONLY IN THOSE CELLS THAT ARE BLUE (unless the instructions specifically request that the applicant provide additional data.)

Demographic data:
Enter the provider name and address in the labeled cells.

Contact information:
Enter the name, telephone number and e-mail address of the person whom EOHHS staff should contact with any questions that may arise during the analysis of the application.

Provider FYE:
Enter the date of the provider's fiscal year end.

Compliance with filing requirements:
Indicate (yes or no) whether or not you have filed financial statements with the Division for the years 2006 and 2007 and whether or not your facility is current with all DHCFP filing requirements. Applications of providers that are delinquent with any filing, including the final 2008 ECPTF grant report, may not be considered.

Enter the total amount of the funding that you are requesting in the box.

BRIEFLY describe the projects for which you are submitting a funding request and the amount for each project. E.g. Purchase CPOE software and supporting hardware, $125,000 or expand diabetes management program staff $65,000. A detailed budget breakdown will be required when the awards are granted.

A Word document limited to TWO printed pages may accompany the application to describe the intended use of the funds, the timeline for the implementation of your project(s), and the outcome measures by which we can assess the success of the sponsored project. You should include in this narrative whether you are applying as a financially distressed provider. You should also include a brief description of any remedial plans that you have implemented or intend to implement with funding from this process to address any current financial difficulties. **This document must use 12 point font with 1" top and bottom margins and 1.25" left and right margins. Failure to adhere to these limits may negatively impact the assessment of your application.** A detailed scope of service will be required based on the award allocation prior to issuing the contract document.

All applicants should complete questions 1-12.

Line 1. Enter the percent of your clinical staff who can communicate in more than one language (e.g., 10%).

Line 2. Enter the percent of the patients that your facility serves that are of racial or ethnic minority (e.g., 10%).

Line 3. Enter the percent of the population served by your facility that is non-English speaking e.g., 10%).

Line 4. Enter whether or not your facility provides smoking cessation counseling services. (yes or no)

Line 5. Enter whether or not your facility provides sexually transmitted disease counseling services. (yes or no)

Line 6. Enter whether or not your facility provides behavioral health services. (yes or no)

Line 7. Enter whether or not your facility provides medical nutrition therapy services. (yes or no)

Line 8. Enter whether or not your facility provides diabetes self-management services. (yes or no)

Line 9. Enter the percent of your patient population that suffers from substance abuse, mental health or other behavioral health disorders (e.g., 10%)

Line 10. Enter the percent of your patient population that is elderly, chronically ill or disabled (e.g., 20%)

Line 11. Indicate whether or not physicians or other providers in your facility enter orders using a computerized system. (yes or no)

Line 12. If you answered “no” in line 11, indicate whether or not your facility will have a computerized system for order entry in place by December 31, 2008. (yes or no)

Only acute hospitals should complete questions 13-15.

Line 13. Enter the percent of the time that your facility notifies a MassHealth member’s primary care physician of an emergency room visit (e.g., 75%).

Line 14. Enter the percent of your patient population that is referred to community-based services for non-emergent care pursuant to 114.6 CMR 13.00 (e.g., 5%).

Line 15. Enter your facility’s market share in your primary service area. This should consider your facility’s number of beds, the number of available beds in your service area, and your competitive position (e.g., 30%).

Only Community Health Centers should complete questions 16-24.

Line 16. Indicate whether or not your facility has open scheduling to treat walk-in patients. (yes or no)

Line 17. Indicate the number of hours during the week that walk-in patients are seen (e.g., 16 hours).

Line 18. Indicate whether or not your facility has extended hours (before 9:00 a.m. and after 5:00 p.m.) Monday through Friday. (yes or no)

Line 19. Indicate the number of hours, from Monday through Friday that your facility offers extended hours (e.g., 20 hours).

Line 20. Indicate whether or not your facility offers weekend hours. (yes or no)

Line 21. Indicate the number of hours that your facility is open on the weekend (e.g., 8 hours).

Line 22. Indicate whether or not your facility offers a program of all inclusive care for the elderly. (yes or no)

Line 23. Indicate whether or not your facility offers 24-hour emergency services. (yes or no)

Line 24. Indicate if your facility qualifies as a “Medical Home” pursuant to the National Quality Forum (NQF). (yes or no)

All applicants should complete questions 25.

Line 25. Indicate any amounts that your facility received in fiscal 2005, 2006, 2007 and 2008 from the Distressed Provider Expendable Trust Fund or Essential Community Provider Trust Fund.

Line 25a. Indicate any funds that your facility received in 2005, 2006, 2007 and 2008 as a result of special appropriations by the legislature.

Line 25b. Indicate any amounts that your facility received in fiscal 2005, 2006, 2007and 2008 from any other state grant program.

Financial Data

CHC applicants and non-acute hospitals should complete financial data items 26-50.

Each applicant must enter their financial data for quarter ended June 30, 2008 Balance Sheet (financial data should be June 30 amounts). Operating statement data should reflect year-to-date numbers. The Division will use cost report data to complete the entries for the prior periods.

Line 26. Cash and liquid investments: enter the amount of cash and cash equivalents (maturity of 90 days or less at acquisition).

Line 27. Board designated assets: enter the amount for assets that your facility’s board of directors has limited the use of that would otherwise be available to fund current operations.

Line 28. Patient accounts receivable net of the allowance for doubtful accounts: enter the amount that represents amounts due and collectible from patients for services provided.

Line 29. Total current assets: enter total current assets from your balance sheet.

Line 30. Accumulated depreciation: enter the amount of depreciation that has been charged to expense for fixed assets according to your facility's depreciation policy. Exclude from this amount any amortization of assets that are not property plant and equipment.

Line 31. Total assets: enter the total asset amount from your balance sheet.

Line 32. Trade accounts payable: enter amounts due and payable to vendors that have provided goods and services to you.

Line 33. Total current liabilities: enter the total of liabilities due to be satisfied during the current operating cycle.

Line 34. Current portion of long term debt: enter the amount of long-term debt that will be paid in the current operating cycle.

Line 35. Long-term debt: enter the balance of long-term debt that is due in subsequent operating cycles.

Line 36. Unrestricted net assets: enter the total unrestricted net assets from your balance sheet.

Line 37. Temporarily restricted donations: enter the amount of temporarily restricted donations recorded for the reporting period.

Line 38. Permanently restricted donations: enter the amount of permanently restricted donations recorded for the reporting period.

Line 39. Net patient service revenue: enter amount of net patient revenue earned during the reporting period.

Line 40. Net operating revenue: enter the net revenue earned from operations for the reporting period.

Line 41. Total operating expenses: enter the total expenses charged to operations during the reporting period.

Line 42. Bad debt expense: enter the estimate of uncollectible revenue charged to expense during the reporting period.

Line 43. Interest expense: enter the total of interest on borrowed funds charged to operations during the reporting period.

Line 44. Depreciation: enter the amount of depreciation on property plant and equipment charged to operations during the reporting period.

Line 45. Amortization: enter the amount of amortization of long-term assets other than property plant and equipment charged to operations during the reporting period.

Line 46. Net income from operations: enter the difference of total operating revenue and total operating expenses for the reporting period.

Line 47. Unrestricted donations: enter the total unrestricted donations recorded for the reporting period.

Line 48. Expenditures for property plant and equipment: enter the amount expended for property plant and equipment for the reporting period.

Line 49. Interest in net assets: enter the amount of interest in net assets of other entities that your facility shows on its balance sheet.

Line 50. Other changes in unrestricted net assets: enter any other changes to unrestricted net assets recorded during the reporting period and describe in the appropriate line.

Line 51. Violations of Debt Covenants: indicate if your facility has been in technical default on any long-term debt instrument at the end of any fiscal year from 2005 through 2008. (yes or no, and provide an explanation if you answer yes).

Line 51a. Material financial deterioration since June 30, 2008: If your facility has experienced a **material** change in financial position from June 30, 2008 through the date of your application filing please briefly describe the circumstances surrounding this change.

All 4 columns should be completed by all applicants

Line 52. Gross patient service revenue: enter total gross patient service revenue for the requested periods.

Line 53. Medicare gross patient service revenue: enter total Medicare gross patient service revenue for the requested periods.

Line 54. Medicaid gross patient service revenue: enter total Medicaid gross patient service revenue for the requested periods.

Line 55. Gross receipts from the health safety net and uncompensated care pool: enter the gross amount of receipts for the requested periods.

Line 56. For hospital applicants only: inpatient days; enter total inpatient days for the requested periods.

Line 57. Emergency Department visits: enter total emergency visits for the requested periods.

Line 58. CHC's only: CHC visits; enter total visits to the CHC for the requested periods.

Contract information (NEW THIS YEAR)

Please enter the contractor information as requested. Completion of this section will hasten our processing of your funding request. The facility information entered here should be as it appears on your Form W-9.

Line 59. Enter the provider's legal name.

Line 60 - 63. Enter the provider's legal street address, city, state and zip code.

Line 64. Enter the state in which the provider is incorporated (if applicable).

Line 65. Enter the provider's state vendor code number.

Line 66. Enter the provider's preferred address for payments.

Contract manager information (NEW THIS YEAR)
The contact information listed should be the person responsible for managing the contract and assuring that all the paperwork is completed, signed and returned in a timely manner.

Line 67. Enter the name of the person who will be responsible for managing the award.

Line 68. Enter the title of the person listed in line 67.

Line 69. Enter the e-mail address of the individual listed in line 67.

Line 70. Enter the telephone number of the person listed in line 67.

Line 71. Enter the Fax number of the person listed in line 67.

Award recipients will be required to submit a detailed budget and scope of service within three (3) days of notification based upon the final award value.

Questions should be directed to Kevin Flynn at 617-988-3206.